Meeting Record

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

November 19, 2015 | 12:30 p.m. - 4:30 p.m. | University of Notre Dame | South Bend

Facilitators:
John Hill, Governor's Office
Dr. John Wernert, Indiana Family and Social Services

Task Force Members:
Dan Miller, Indiana Prosecuting Attorneys Council
Dr. Charles Miramonti, Indiana University Medicine/Indianapolis EMS
Reverend Rabon Turner Sr., New Hope Missionary Baptist Church
Judge Roger Duvall, Scott County Circuit Court
Dr. Jerome Adams, Indiana State Department of Health
Senator Jim Merritt, Indiana State Senate
Mary Beth Bonaventura, Indiana Department of Child Services
Senator Jim Arnold, Indiana State Senate
Superintendent Doug Carter, Indiana State Police
Justice Mark Massa, Indiana Supreme Court
Commissioner Bruce Lemmon, Indiana Department of Correction
Sheriff John Layton, Marion County Sheriff Department
Judge Wendy Davis, Allen County Superior Court
Dr. Joseph Fox, Anthem, Inc.
Tony Gillespie, Indiana Minority Health Coalition
Dr. Tim Kelly, Community Health
Chief Michael Diekhoff, Bloomington Police Department
Representative Terry Goodin, Indiana House of Representatives
Representative Wendy McNamara, Indiana House of Representatives
Dr. Joan Duwve, Indiana State Department of Health
Bernard Carter, Lake County Prosecutor

Others Present:
Presenters:
Commissioner Bruce Lemmon, Indiana Department of Corrections
Judge Kim Hall, Starke County Circuit Court
Deborah McMahan M.D., Allen County Health Commissioner
Chris Johnson, Indiana Family and Social Services Administration
Kevin Moore, Indiana Family and Social Services Administration
Sharon Burden, Partnership for Education and Prevention of Substance Abuse
Jan Noble, Elkhart County Drug-Free Partnership
Jim Starkey, Elkhart County Drug-Free Partnership

Staff Support to the Task Force Present:
Veronica Schilb, Office of the Governor
Devon McDonald, Indiana Criminal Justice Institute
Adam Backer, Indiana Criminal Justice Institute
Mary Kay Hudson, Indiana Judicial Center
Diane Haver, Indiana Judicial Center

Public:

Bill Dulin	Kerry Hershberger	Michael Mitchoff
Sharon Burdou	Bill Skidmore	John Thorstad
Kim Hall	Tricia Rogers	Deborah Shubert
Jason Jablonski	Beatrice Owen	Amanda Morrison
Molly Wehrenberg	Tandra Johnson	Jessica Crosor
Lauren Varga	Cindy Bodle	Kent Laudeman

Meeting Summary:

- Presenters from various disciplines spoke on how their professions, counties, and local communities have been impacted by drug addiction.
- Presenters offered recommendations to the Task Force and requested the consideration of their proposals.
- Task Force members were given the opportunity to pose questions to the presenters.
- Three members of the public provided testimony and offered recommendations relative to the topic.
- Task Force members discussed potential action items and recommendations for Governor Pence.
- Two motions were passed.

Presentations:

Judge Kim Hall

Judge Kim Hall with Starke County presented on the judicial perspective related to drug abuse. Judge Hall served as a prosecutor for 18 years. During practice, he sought to put drug dealers in prison for the maximum amount of time possible. While on the bench, Judge Hall began to take note on the repeat offenders returning to his courtroom. Judge Hall stated that he was teaching but no one was learning. The offenders he sentenced while in their 20's are now in their 50's, still returning for the same crimes. He noted to the Task Force that the old approach of incarceration has not proven to be effective and it is expensive. Judge Hall explained that once he decided that the status quo was not acceptable, he began to look at evidence-based practices. Specifically, Judge Hall looked into the therapeutic community programs found in prisons. In order to receive the program, an individual must be sentenced for a long period of time. Once he or she completes the program, their sentence will likely be modified. Judge Hall estimated that 90% of prisoners receive a modified sentence upon completion and the majority do not come back to court. Judge Hall would like to see a program like the therapeutic community in the local jails. Their local sheriff is committed to the idea and agrees that treatment must be in the jails. Not only will it save the state money, but it will also generate money for the sheriff. Judge Hall honed in on five reasons to keep the program local and allow for the implementation in Starke County:

1. Starke County shares a border with seven additional Northern Indiana Counties. Between 2011 and 2013, Starke County led the state in the number of meth labs seized. The surrounding counties followed closely behind. The area is in the heart of methamphetamine addiction.
2. Starke County has a new jail. The Sheriff is willing to designate two pods specifically to therapeutic communities. They will have special guards and remain separate from the general jail population. Additionally, they have a new court room that would be made available to this population.
3. The state will reimburse the local jail $35 per day for each DOC inmate housed in the jail. The cost per day for the 1700 individuals in prison and therapeutic communities can be reduced by 10 million dollars if housed in the local jails.

4. Research has shown that those who participate in therapeutic communities thrive when closer to family and support systems. The local jails would provide more opportunity to keep the participant in touch with their support systems.
5. Judges have been trained on evidence-based practices, risk assessments, cognitive behavior therapy, etc. and are learning that simply maxing an offender out on his or her sentence is not effective. Judge Hall surveyed 20 judges in the surrounding counties and all agreed to recommend to the DOC to place the individuals in the local therapeutic communities and they also agreed to consider the modification of sentence upon completion.

Judge Hall continued with the benefits of housing therapeutic communities at the local level. First, the individuals will remain closer to their support systems, closer to the sentencing court, and closer to their probation department and community corrections for assessment. Second, they will receive the same treatment and time reduction they would have received in DOC. Additionally, the program would work to reduce recidivism among community members and provide the sheriffs with funds for their facilities.

Judge Hall answered questions from the Task Force.

Commissioner Bruce Lemmon
Commissioner Bruce Lemmon was appointed by Governor Pence in 2013 and also served under Governor Daniels. Commissioner Lemmon provided continued detail related to therapeutic communities. He explained that after the order of a lengthy sentence, the individual is sent to the DOC and placed directly into the therapeutic community. The participants house together, eat together, work the program together, and recreate together. It may take 8-12 months for the individual to complete the program. Therapeutic communities can be found in Westfield, Plainfield, Branchville, and Madison. The Cliff Units, which are specialized therapeutic communities that focus on methamphetamine and cocaine addictions, can be found in the Logansport Juvenile facility and in Putnamville. The program in Putnamville recently doubled the beds due to its noted success. Currently, there are 2300 total therapeutic community beds in the Indiana DOC facilities. Commissioner Lemmon explained the concept of a reentry court and referenced Judge Tockman's reentry court in Vanderburgh County. The reentry courts provide aftercare for those reentering society after incarceration and participants serve as mentors to one another while holding one another accountable. Through the reentry court, the participants are linked to anger control classes and parenting programs in order to reconnect with families and children. The key component is that the programs are local, allowing the participant to connect with their families and support systems.

Commissioner Lemmon spoke on recidivism. He noted that 36% of DOC inmates will recidivate, but that number is reduced by half for those who complete therapeutic communities. Commissioner Lemmon proposed to the Task Force the implementation of a Purposeful Incarceration. He stressed that the program would include a mental health component in addition to the standard model. The funding would be covered by the $35 per day state reimbursement. Commissioner Lemmon proposed a partnership with the local treatment provider, Horizon, in order to provide treatment for participants. DOC would cover that cost.

Commissioner Lemmon answered questions from the Task Force

Dr. Jerome Adams
Dr. Jerome Adams provided a refresher and an update relative to the last Task Force meeting held on October 15, 2015 in Southern Indiana. At that time, the first recommendation of the Task Force was *to direct the State Department of Health to convene a work group to send recommendations of improvement and evidence-based practices related to INSPECT to the INSPECT Oversight Committee.* Dr. Adams informed the Task Force that the INSPECT Oversight Committee met and were receptive to the ideas.

Action items resulted from the INSPECT Oversight Committee's first meeting. The INSPECT Oversight Committee agreed to the automatic registry process for pharmacies and would like to do the same for providers. Additionally, they approved the removal of the notary requirement for registry of INSPECT. The INSPECT Oversight Committee will work on a fact sheet that will include information relative to what the user can do with the information provided by INSPECT. Dr. Adams reminded the Task Force of the second recommendation, *to direct the State Department of Health to guide physicians, nurse practitioners, veterinarians, dentists, and podiatrists with guidelines related to the prescription of acute pain medications.*

Deborah McMahan, M.D.
Dr. Deborah McMahan spoke on the opiate crisis among the residents in her county and within the United States. Dr. McMahan noted that it began as a prescription problem and is now an epidemic that must be addressed. In Allen County, for example, much of the labor force is made up of blue-collar jobs and it is not uncommon for those employees to become injured while working. Typically, they are the primary salary earner. Often the injury becomes a chronic issue of which they seek medical care, and eventually the opiate process begins. Dr. McMahan explained that the physicians do not screen patients for or against the use of opiates, nor do they screen during the use of the medications. Physicians also do not screen for mental illness. Dr. McMahan explained that physicians do not want to upset the patient by not treating pain with medications, which has led to the current problem.

Dr. McMahan is devoted to decreasing the endless supply of opiates. She reported that our country consumes the most opiates in the world while only populating 5% of the world. 109 opiate prescriptions are written for every 100 people. Patients become addicted to the opiates unintentionally. The lack of screening for anxiety or depression, conditions that opiates may often improve, can lead to addiction. Dr. McMahan noted that people generally believe that opiate consumption is safe because they are not "street drugs" and physicians prescribe the medications. This perception has created an influx on the illicit use among teenagers. Dr. McMahan reported that 60% of teens who are abusing opiates began using before the age of 16. There is a high rate in accidental overdose among all opiate users. Additionally, opiates are overprescribed by veterinarians, dentists, in the emergency rooms, and for post-operation. Professionals will even prescribed to people who request something other than opiates.

Dr. McMahan reported that heroin use has increased among people who started with prescription drugs. Patients may turn to heroin when there is a lack of capacity to absorb the need when the pill mills shut down. Heroin use often leads to the sharing of needles and the spread of hepatitis C and HIV. Dr. McMahan noted that the epidemic is a problem for everyone and the de-stigmatization must take place. This silent epidemic of addiction will have a long-term impact on economic and social conditions. Dr. McMahan presented to the Task Force "Jim's Story," which is provided at the following link: https://youtu.be/5e61XGQ2oYY

Dr. McMahan stated that this is a crisis epidemic. The solution is not the same as it has been in the past. Big changes must occur. Dr. McMahan recommended advocating for more school involvement and education. There is nothing available for kids. She feels that schools should be required to educate students on opiates and illegal drugs. She further recommended increased mental health screenings and increased collaborative work on these issues.

Dr. McMahan answered questions from the Task Force

Chris Johnson
Chris Johnson is the director of pharmacy for the state and oversees the Hoosier prescription benefits through the Indiana Family and Social Services Administration. Mr. Johnson has proposed the Gold Card Program, which would improve the access to medicated assisted treatment. The Gold Card would

increase access to MAT treatment for certified addiction providers by reducing the barriers for those who are authorized to prescribe. The Gold Card would allow for physicians who meet particular qualifications to have the qualifying prescriptions within their program without the administrative burden. If approved, they would like to implement the Gold Card at the first of the year. They are working to build their number of providers who can administer the prescription. They are seeking physicians who are certified psychiatrists who have completed particular trainings. Providers who warrant specific trainings will be flagged for the Gold Card. The Gold Card providers will still be required to adhere to the evidence-based criteria. Those who oversee the Gold Card will review the prescribing patterns of the Gold Card providers and will ensure proper adherence to record retention. The providers will understand that it is the agency's right to revoke the Cold Card, if found necessary. As the bench for the Gold Card Program is built, addictionologists will be included.

Mr. Johnson answered questions from the Task Force.

Kevin Moore

Kevin Moore serves as the director of the Division of Mental Health. He presented to the Task Force information on the mental health and addiction forensic treatment fund that serves to connect individuals who struggle with addiction to treatment while remaining in the community. Mr. Moore began by providing the scope of the issue. Our nation releases 650,000 individuals from prison each year. Indiana releases 18,000 inmates annually. The criminal justice system has remained the largest treatment referral agent, which includes the courts, parole, etc. About 14.5% of males housed in the jails have a diagnosable mental illness. About 14% of DOC inmates are on psychotropic medications for a diagnosed mental illness. Comparatively, only 5.4% of the general public are on psychotropic medications for a diagnosed mental illness. Upon admission to the DOC, 80% of inmates are in need of substance abuse treatment, which supports the importance of the therapeutic programs in the DOC. To put these numbers in perspective, only 8.8% of the general public have the same need.

Mr. Moore explored Recovery Works and how it aims to connect treatment to community supervision. Treatment must be of high quality, grounded in evidence-based practices, and include appropriately trained staff. Integrated care is critical for the continuum of care. Community supervision requires an individualized approach, based on the results of a risk and needs assessment that will target multiple criminogenic needs. Funding resources have been variable, but now more people will have access to funding for care. Collaboration between community supervision and the treatment provider is essential. Mr. Moore reported that with HEA 1006, the Department of Mental Health and Addition (DMHA) has been granted funds that will support the services for justice-involved individuals who lack coverage but are in need of treatment. Mr. Moore points to slides 74 and 75 for eligibility criteria. Providers will receive a voucher reimbursement to provide the services to those without their own coverage. Mr. Moore referenced www.recoveryworks.fssa.in.gov to access the current list of designated providers. Slide 78 notes what services are covered under Recovery Works. Slide 79 notes how the process of Recovery Works unfolds. Mr. Moore ended by explaining that Recovery Works is used as a supplement to community supervision strategies that will decrease recidivism and will allow for the access to individualized treatment and recovery services. The vouchers began on November 1st. At the time of this meeting, a Recovery Works certified agency was available in 69 of the 92 Indiana counties. They anticipate coverage across all counties as the roll out continues. The Justice Reinvestment Advisory Council serves as their accountability body, assists in the direction of Recovery Works, and will also collect the data.

Mr. Moore answered questions from the Task Force.

Jim Starkey, Jan Noble, & Sharon Burden

Jim Starkey, president of Elkhart County Drug Free Partnership, presented on local coordinating councils (LCCs) and what they are doing to address drug addiction in their communities. They have a local comprehensive drug and alcohol abuse plan. They serve to identify what community resources are available and collaborate with local law enforcement for anti-drug efforts. The council collects and monitors local data and evaluates the supporting entities available. The local perspective is important since they are aware of the problems that exist in their communities and see the trends that are routinely noted. For example, Elkhart County does not currently have a heroin problem, but they have taken note on the issue in a neighboring county believe the trend could enter their community. They provide grants, scholarships, and local data that is useful to identify the trends. The local council determines the requirements to become a member. The members include a variety of professions, such as treatment providers, local judges, law enforcement, a faith based representative, etc. Each county determines their own membership and completes a comprehensive community plan to assess the impact of drug abuse in the area while pulling from the data in order to derive the plan. They work to identify the gaps and barriers in resources for recovery and pull from the existing resources. Mr. Starkey explained to the Task Force the purpose of the three-year comprehensive community plan. The plan must be approved by the Indiana Criminal Justice Institute before they administer vouchers. The comprehensive community plan addresses the drug and alcohol issues at the local level that are identified through local needs assessments. They seek community feedback from various agencies, such as local law enforcement, treatment providers, schools, parents, etc. They develop a list of priorities while drafting measurable and realistic goals. They report their findings to the state every year to show if the grantees met their goals. LCCs are required to give priority to evidence-based programs.

Ms. Sharon Burden is with the Alcohol and Drug Addictions Research Center in South Bend, Indiana and is the Chair of the local coalition, PEPSA, also in South Bend Indiana. Ms. Burden has been a member of the coalition since it began in 1989. They have 40 members that meet every other month. The coalition has worked diligently to ensure the membership is representative of the community. Their membership includes treatment and prevention representatives, school representatives, the local drug court judge, community corrections and law enforcement representatives, faith-based representation, and concerned citizens. The comprehensive community plan involves a committee that compiles the plan. They gather the perspective of the agency in order to consolidate the plan based upon the input received. They respond to local issues. Specifically, they are dealing with an opiate issue in St. Joseph County and used their local dollars to purchase a medication drop box. They now have three medication drop boxes in St. Joseph County. The organization just launched a website, http://www.pepsasjc.org to provide information to the public.

Jan Noble with Addiction Recovery Centers, spoke to provide examples of the plans derived from the LCC had been put into action. Mr. Noble is the co-coordinator for the Elkhart County LCC. Prevention is an area that is difficult to quantify the results. They worked with social norms to address the issues. Mr. Noble provide the example of the Amish community in Elkhart County. He reported that the law enforcement was at one time consumed with reports within the Amish community. The LCC eventually funded the criminal justice initiatives to address the parties and violence in the Amish communities. Now, treatment and financial aid from the LCC is aimed towards those who cannot afford their treatment. Additionally, their local officers now carry Narcan.

Mr. Starkey noted that their focus remains on the larger picture and they attempt to stay ahead of the problems by speaking with individuals from other states on the issues they are facing. Medication boxes are made available at every police station in the county. They look at the trends in surrounding states in order to determine what may come to Indiana. The Local Coordinating Council spoke on the daily challenges their community faces relative to drug addiction in their community. Their aim is to help communities deal with the drug addiction problem in their community.

Jim Starkey, Jan Noble, and Sharon Burden answered questions from the Task force.

Public Testimony

Deborah Shubert
Deborah Shubert presented to the Task Force her experience with many attempts to find treatment assistance for a loved one. Ms. Shubert noted that she would spend hours on the phone in an effort to locate resources for her loved one, a college athlete who later struggled with addiction. Ms. Shubert illustrated how recovery is often hindered by other barriers. She noted that an individual suffering from addiction may lose family support, employment, and hope. Thus, the person later continues with no insurance and faces homelessness. She questioned, "How are they supposed to attend an inpatient program with all those other burdens? It takes 10-12 weeks to get into treatment." Ms. Shubert listened to the presenters during this meeting and agreed that the resources available through Recovery Works are great, but asked the Task Force to consider the needs of those who have not yet landed in the criminal justice system.

Tricia Rogers
Ms. Tricia Rogers spoke to the Task Force on the difficulties of watching a child to suffer with addiction. She reported that there is a great deal of peer pressure in middle school and high school. The perception is that everyone is using. Ms. Rogers noted that new evidence suggests that some individuals are more vulnerable to addiction than others. The dopamine is opened upon use, creating addicts who will engage in terrible behaviors to acquire more of the drug. The drug become like food and water for the addict. Ms. Rogers suggested a need to form small groups that have innovative programs with families and schools being the base for such programing.

Tandra Johnson
Dr. Johnson presented on the dangers of THC as a gateway drug and the long road to recovery upon which her son and family walked. She made note of the important work of the Task Force and thanked the members for being at the meeting. Dr. Johnson is a mother of an addict and explained that you feel hopeless with nowhere to turn and face a range of emptions while attempting to help your loved one. Her son began using marijuana and she thought he would eventually stop using. Dr. Johnson stressed that marijuana is a gateway drug that led to her son's use of other drugs and he eventually dropped out of school. She noted that many parents use marijuana, providing poor examples to their children. Dr. Johnson is concerned about the states who will change the marijuana laws and asked how we can protect our state. Dr. Johnson walked the Task Force through the recovery of her son. She noted that employment was critical to his recovery. Her son has been drug free since May 9, 2015. Prior to May, he had not been sober for a period longer than 48 hours in over 20 years. Dr. Johnson stressed that employment is a key aspect and recovering addicts will not succeed without such a tool. Employment provides accountability and clear thinking. Dr. Johnson stressed that drug addiction is a family affair, but many families do not have the resources or know where to turn for help. She was overwhelmed even with support and resources available. Dr. Johnson suggested family courts as an option.

Discussions:

Senator Merritt spoke to the Task Force and encouraged the Task Force to come up with a practical way to approach the General Assembly. He explained that the language related to addictions should be softened in order to humanize it and remove the stigma. It is a disease - not a character flaw - that is strangling our communities. Senator Merritt committed that he and Senator Arnold will do their best to represent the topic. He would like to expand the Lifeline Law for those in need of medical attention, expand on the Narcan limitations, and expand the use of INSPECT. He also reported that he would like to see the implementation of some sort of consequence for those who falsify a drug screen. Senator

Merritt ended by noting that their responsibilities do not stop with the meetings and they must look into the future. It is important to consider the frameworks of the drug free organizations, determine if the right plans and actions are in place, and determine if everyone is going in the same direction. Efficiency and time well spent is key.

Senator Jim Arnold proposed the endorsement of the concept of the regional therapeutic community pilot. All were in favor. None opposed.

Dr. Adams informed the Task force that discussions had occurred related to the security and data of INSPECT. Dr. Adams agreed to take the recommendations back to the committee. Dr. Adams asked that the Task Force look at all measures to increase the availability of INSPECT access to providers. He noted that the INSPECT Oversight Committee considered the recommendations that resulted from the last Task Force meeting.

After discussion, Senator Merritt withdrew his recommendation to implement a penalty consequence for those who falsify a drug screen.

Preliminary drafts for the Lifeline Law and for the Narcan standing order for pharmacies were passed out to the Task Force members.

The action items were summarized by Mr. Hill and were as follows:

- Direct the Department of Correction to work with Starke and other northwest Indiana counties to adopt and pilot the Regional Therapeutic Communities program, which provides more treatment options for local officials in addressing drug addiction.

- Direct the Professional Licensing Agency, to request that the INSPECT Oversight Committee explore possible measures to increase access to INSPECT for prescribers and dispensers (For more information on INSPECT, visit:http://www.in.gov/pla/inspect/).

- Support the following legislative items, authored by Sen. Jim Merritt, by including them on the Governor's legislative agenda:

    - Expand the Lifeline Law to include immunity beyond alcohol offenses.
    - Amend state law to require the Indiana State of Department of Health (ISDH) to issue a standing order for the dispensing of an overdose intervention drug, such as naloxone. This standing order will enable certain entities such as pharmacies to sell the drug to an individual without needing a prior prescription from a physician.
    - Modify the Commission for a Drug-Free Indiana in a way that maintains support for local coordinating councils (LCCs) but brings together state agencies and stakeholders to address the drug abuse issues Indiana is facing today.

- Direct the Indiana Family and Social Services Administration to implement the Gold Card Program, which removes administrative burdens by allowing qualified physicians the ability to prescribe medications without prior authorization. The prior authorization process enables payers like the Indiana Medicaid Program a chance to review the medical evidence of a member's health condition, as provided by the treating physician, so that the medical need for covering the service and treatment costs can be established.

Motion by Senator Merritt seconded by Mary Beth Bonaventura for the Task Force committee to approve the five discussed action items. Motion passed with Mr. Dan Miller opposing.

Motion by Dr. Wernert and seconded by Mary Beth Bonaventura to endorse the Gold Card Program. Motion passed.

Dr. Adams recommended the initiation of an anti-stigma campaign. After discussion, Mr. Hill asked if the Task Force would agree to pull from one another's agencies in order to adopt a formal message to be release accurately. The Task Force members agreed.

Dr. Kelly provided to the Task Force the following article:
Wilson, R. (2015). How America's "heroin city" is turning itself around. *AP The Big Story,* Retrieved from http://bigstory.ap.org/article/b2bbf7f7b19546fb9e86559634f031d3/how-americas-heroin-city-turning-itself-around

The Task force meeting adjourned at 4:40 pm.

Meeting Agenda

Governor's Task Force on Drug Enforcement, Treatment, and Prevention

November 19, 2015 | 12:30 p.m. - 4:30 p.m. | University of Notre Dame| Notre Dame

12:30 p.m. – 12:35 p.m.	**Welcome** John Hill & Dr. John Wernert, Co-Chairs, Governor's Task Force on Drug Enforcement, Treatment, and Prevention
12:35 p.m. – 1:20 p.m.	**Enforcement – Therapeutic Communities** Commissioner Bruce Lemmon, Indiana Department of Correction Judge Kim Hall, Starke County Circuit Court *Task Force Discussion*
1:20 p.m. – 2:05 p.m.	**Treatment – Acute Pain Prescribing** Deborah McMahan M.D., Allen County Health Commissioner *Task Force Discussion*
2:05 p.m. – 2:45 p.m.	**Treatment – Gold Card & Recovery Works Programs** Chris Johnson, Indiana Family and Social Services Administration Kevin Moore, Indiana Family and Social Services Administration *Task Force Discussion*
2:45 p.m. – 3:30 p.m.	**Prevention – Local Coordinating Councils** Sharon Burden, Partnership for Education and Prevention of Substance Abuse Jan Noble and Jim Starkey, Elkhart County Drug-Free Partnership *Task Force Discussion*
3:30 p.m. – 4:00 p.m.	**Public Comment**
4:00 p.m. – 4:30 p.m.	**Task Force Discussion on Recommendations**

* GOVERNOR'S *

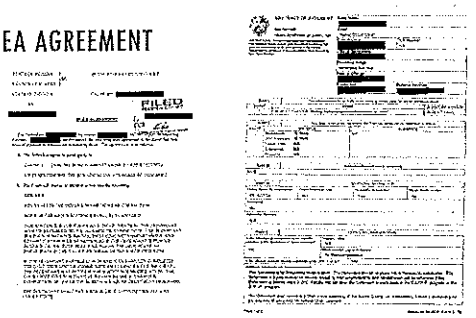
TASK FORCE

on Drug Enforcement, Treatment & Prevention

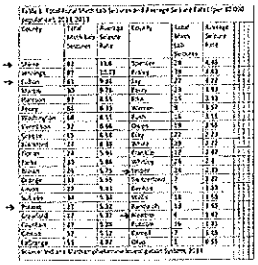
REGIONAL THERAPEUTIC COMMUNITIES

Judge Kim Hall,
Starke County Circuit Court

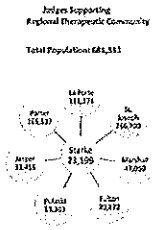
PLEA AGREEMENT



RURAL METH LAB SEIZURES



JUDGES SUPPORTING REGIONAL THERAPEUTIC COMMUNITY



BENEFITS OF REGIONAL THERAPEUTIC COMMUNITIES

- Inmates closer to important family support
- Inmates closer to court for modification
- Inmates closer to community corrections and probation for assessment for:
  - Work release
  - Home detention
  - Probation
- Same treatment and same time out
- Same reduction of recidivism, if not greater
- Provide sheriffs with funds to improve jail services in facilities throughout Indiana
- Lower costs with better outcomes

The Opiate Crisis in Allen County

Deborah McMahan, MD
Health Commissioner

Causes

What I Know is True

- This is a epidemic that started as a prescription opiate drug issue and has evolved into an illegal opiate issue.
- The CDC determined in 2010 that prescription drug abuse was an epidemic.
- Our community began addressing this issue at that time and joined with the Attorney General's Task Force a few years later.

Causes – From My Perspective

Everyone owns a part of this problem - **Government**

- CMS determined that healthcare was not properly addressing pain control and made pain the 5th vital sign,
- Created an expectation that all pain should be controlled and/or controllable.
- FDA continues to approve more and more pain medications

Causes – From My Perspective

Everyone owns a part of this problem - **Patients**

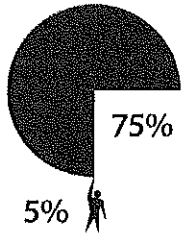
- Patient perception that prescriptions are not only safe but that doses are universal and can therefore be stored for later use and/or given to others in need.
- High rates of chronic health issues in Allen County that contribute to acute injury and chronic pain issues in our workforce -- which includes a lot of manual labor jobs.

Causes – From My Perspective

Everyone owns a part of this problem - **Healthcare**

- A lot of undiagnosed and untreated mental health issues that contribute to addiction.
  - -- Including teens and young adults
- The "retailization" of healthcare where patient satisfaction is the primary goal.
- Patients and providers do not want to be inconvenienced by having to refill a prescription -- so give them 40 instead of 20 and a refill.

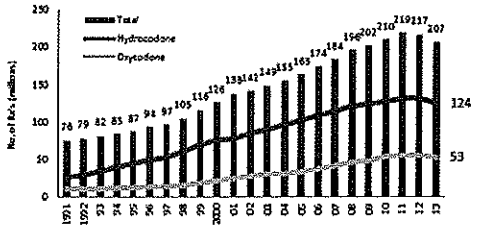
Causes – Supply



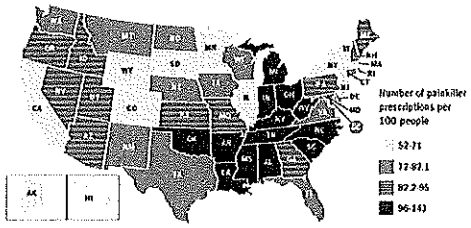
Americans and Hoosiers have had ready access to prescription drugs for years

Americans make up less than five percent of the world's population but use 75 percent of the global supply of opioids.

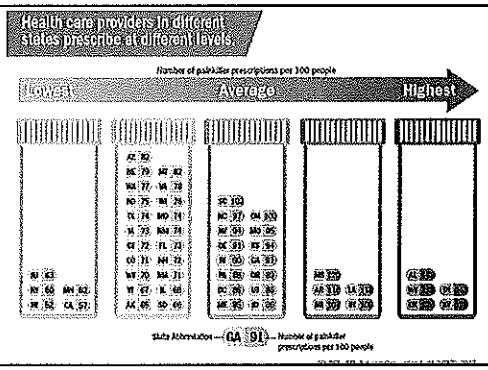
Opioid Prescriptions Dispensed by US Retail Pharmacies



State Painkiller Prescriptions per Person



http://www.cdc.gov/media/releases/2014/p0704-opioid-painkiller.html



Why is This Extraordinary Supply of Opiates a Problem?

We have vulnerable people

Mental Illness Treatment

- Only about one-third of those suffering from anxiety receive treatment
- Overall, only about half of Americans diagnosed with major depression in a given year receive treatment for it, and even fewer—about one fifth—receive treatment consistent with current practice guidelines,
- These folks are vulnerable to becoming unintentionally addicted.

Addiction and Mental Illness

- Research suggests that about 20 percent of people who have a mood disorder like depression also have a substance abuse disorder
- People with mental health problems such as anxiety and depression are more likely to use painkillers on a long-term basis.

Chronic Pain

Condition	Number of Sufferers
Chronic Pain	100 million Americans
Diabetes	25.8 million Americans (diagnosed and estimated undiagnosed)
Coronary Heart Disease (heart attack and chest pain)	16.3 million Americans
Stroke	7.0 million Americans
Cancer	11.9 million Americans

Chronic Disease and Depression

- About 50 percent of people who have chronic pain also have depression
- The presence of diabetes doubles the odds of comorbid depression.
- Up to 15 percent of patients with cardiovascular disease and up to 20 percent of patients who have undergone coronary artery bypass graft (CABG) surgery experience major depression.

Indiana Teens

- Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)

  29%
- Seriously considered attempting suicide in last year

  19%

Mental Illness and Addiction

- In fact, 90 percent of all adults with a substance use disorder started using under the age of 18 and ***half under the age of 15.***
- 60 to 80 percent of adolescents with substance use disorders have a co-occurring mental illness.

Why is This Extraordinary Supply of Opiates a Problem?

People think they are safe

Teen Perceptions

- Fifty-six percent of teens believe that prescription drugs are easier to get than illicit drugs.
  - Sixty-three percent of teens believe that prescription drugs are easy to get from friends' and family's medicine cabinet.

http://www.justice.gov/dea/concern/prescription_drug_fact_sheet.html

Teen Perceptions

- Two in 5 teens believe that prescription drugs are "much safer" than illegal drugs.
- ***And 3 in 10 teens believe that prescription pain relievers are not addictive.***

http://www.justice.gov/dea/concern/prescription_drug_fact_sheet.html

Why is This Extraordinary Supply of Opiates a Problem?

Because we create addicts

...many of whom are working and increasing workplace accidents

Epidemiology

- Every day, on average, 2,500 teens use prescription drugs to get high for the first time.
- 1 in 7 teens admit to abusing prescription drugs to get high in the past year.
- Sixty percent of teens who abused prescription pain relievers did so before the age of 15.

http://www.justice.gov/dea/concern/prescription_drug_fact_sheet.html

Teen Prescription Drug Abuse

* Ever took prescription drugs without a doctor's prescription					
Female	CI	Male	CI	Total	CI
19.8	17.8-21.9	21.5	19.9-23.2	20.7	19.2-22.2
Indiana					
* Ever took prescription drugs without a doctor's prescription					
Female	CL	Male	CL	Total	CL
21.5	18.7-24.5	21.3	16.4-27.2	21.4	18.3-24.8

United States, Youth Risk Behavior Survey, 2011

Mental Health and Addiction

- Teenagers and young adults are more likely than older adults to abuse or become dependent on opioid painkillers.
- An analysis of national studies from 2002 to 2004 found that people ages 12 to 25 were abusing or dependent on painkillers — roughly double the percentage in people ages 26 to 49, and six times the percentage in those 50 and older.

Drug Abuse in the Workplace

- More than 70 percent of substance abusers hold jobs; one worker in four, ages 18 to 34, used drugs in the past year; and one worker in three knows of drug sales in the workplace.
- They increase risk of accident, lower productivity, raise insurance costs, and reduce profits. They can cost you your job; they can cost you your life.

Drug Abuse in the Workplace

Compared to their non- abusing coworkers, they are:

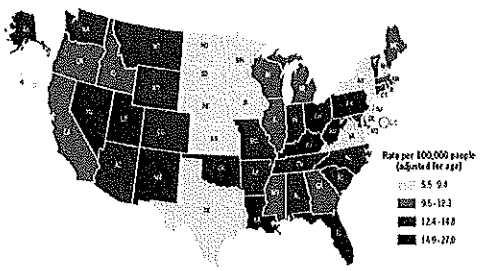
- Ten times more likely to miss work
- 3.6 times more likely to be involved in on-the-job accidents (and 5 times more likely to injure themselves or another in the process)
  - they are also responsible for 40 percent of all industrial fatalities.
- Five times more likely to file a worker's compensation claim
- 33% less productive
- Responsible for health care costs that are three times as high.

http://www.acde.org/employer/DAwork.htm

Why is This Extraordinary Supply of Opiates a Problem?

Because people accidentally die

Drug Overdose Death Rates by State



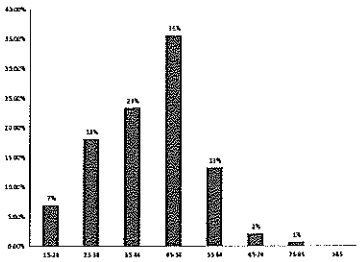
Allen County OD Deaths

- Collaborative Study
  - Fort Wayne-Allen County Department of Health
  - Allen County Coroner's Office
  - Fort Wayne Medical Education Program
- Lutheran Hospital of Indiana IRB
- Reviewed Death Certificate
- Reviewed Coroner's File
  - Coroner's Report
  - Toxicology Report
  - Police Report
  - Other Documents

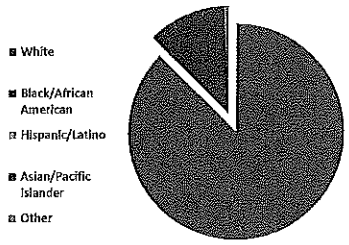
Overdose Rates

- 287 Overdose Deaths
- 2010 Allen County Overdose Death Rate 12.9 per 100,000
- 2013 Estimated Overdose Death Rate: 17.1 per 100,000
- In 2013 in Allen County, overdose deaths ***equaled*** Motor Vehicle Deaths
  - **11%** Increase in MVA deaths over study period ***versus 55% increase in OD deaths.***

Age



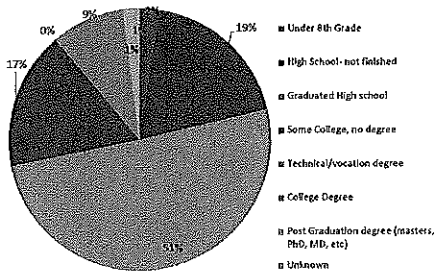
Race



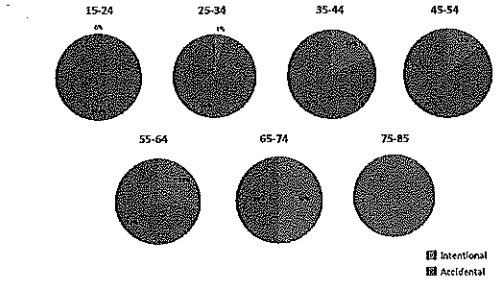
Demographics

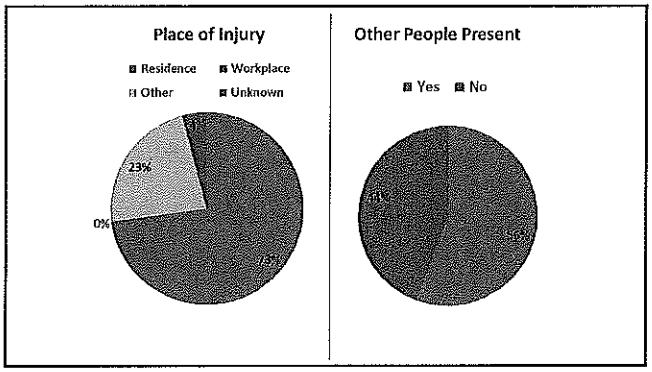
- Employment
  - **64% Employed**
  - 18% Unemployed
  - 4% Student
  - 9% Disabled
  - 5% Unknown

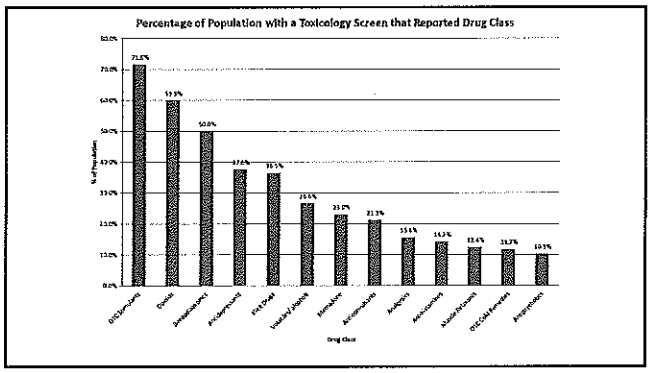
Education



Manner of Death by Age







Accidental Overdoses in Allen County

- January – September 30, 2014 Total 32
- January-September 30, 2015 Total 44

This is a 40% increase this year

What to Do?

How do We Decrease the Supply?

- New prescribing rules for chronic pain and the toolkit were a good start.
  - Gives well-intentioned providers legal cover
  - Makes physicians think first before starting something they know they may have to stop

Gaps in Limiting Supply

- Not everyone has to abide by the new prescribing rules
  - E.g. dentists
- Still overprescribing for acute pain both in ER and in Primary Care Offices
- Too many Post op pain meds
- We still prescribe opiates for former addicts

Collateral Issues

As we reduce the supply, the cost goes up and heroin is cheaper…

Heroin

- The only increases in past year heroin use were observed among persons who reported past year nonmedical use of opiates (not prescribed for them).
- In a sample of heroin users in a treatment program, 75% of those who began opioid abuse after 2000 ***reported that their first regular opioid was a prescription drug***.

Heroin

- It is estimated that about **23 percent** of individuals who use heroin become dependent on it.
- Heroin can be injected, inhaled by snorting or sniffing, or smoked.
- Studies indicate an increasing problem with fatal overdoses from heroin from 2010 to 2012.

Heroin

- This ain't your Momma's heroin
- More potent
- Laced with fentanyl
- More overdoses

Officials in Chicago suspect heroin laced with fentanyl responsible for 74 overdoses in three days

Fentanyl Seizures

- More than 80% of drug seizures in 2014 were concentrated in 10 states (Table 1). The number of states reporting 20 or more fentanyl seizures every six months is increasing. From July to December 2014, 18 states reported 20 or more fentanyl drug seizures

Table 1: Top 10 states by total Fentanyl Seizures, 2014, compiled from STRIDE data

Rank	State	Number of Fentanyl Seizures
1	Ohio	1245
2	Massachusetts	830
3	Pennsylvania	439
4	Maryland	311
5	New Jersey	238
6	Kentucky	232
7	Virginia	222
8	Florida	183
9	New Hampshire	177
10	Indiana	153

Significant Community Issues

- Increased HIV/ Hepatitis C infections in people who inject drugs.
- Lack of capacity for providers to absorb mismanaged chronic pain patients when pill mills shut down.

Gaps

- Lack of community awareness and understanding addiction
- Lack of routine screening for addiction and mental health – especially with young people
- Access to mental health and addiction specialists who can provide treatment
- The expense of treatment
- Disengaged medical community
- Routine access to clean needles and equipment
- More access to narcan

Summary

- My community has been greatly affected by the silent epidemic of addiction.
- Two cases of ebola in the US and everyone began to was on board to do whatever was necessary to protect our citizens.
- Addiction, with the long term economic and social impact and high mortality deserves no less.

Jim's Story

https://youtu.be/5e61XGQ2oYY

* GOVERNOR'S *
TASK FORCE
on Drug Enforcement, Treatment & Prevention

IHCP Gold Card Program

Removing Administrative Burden to Ordering Medication Assisted Treatment with Buprenorphine

Addictions Task Force Meeting
November 19, 2015
University of Notre Dame

What is a Gold Card?

- A Gold Card program eliminates the administrative burden of submitting medical records to payers for authorization of therapies for payment.
- Gold Cards are assigned to prescribing physician providers
- IHCP's Gold Card Program will enable qualifying prescribing physicians to order MAT for opioid addiction.
- If approved, anticipated Effective Date of January 1, 2016.

How Are Gold Cards Assigned?

- Gold Cards are awarded to physicians, based on:
  - IHCP enrollment.
  - Appropriate specialization.
  - Completion of training.
  - Compliance to Federal and State requirements.
  - Possession of necessary licenses and certifications.
  - Agreement to the provisions of a Gold Card provider.

Maintaining a Gold Card

- Maintaining a Gold Card status is based on:
  - Duration of the prior authorization requirement.
  - Prescriber adherence to treatment guidelines as supported in retrospective reviews or onsite audits.
  - Prescriber's completion and maintenance of medical records as required.
  - Prescriber's compliance to Federal and State requirements.
- Prescribers assigned a Gold Card status agree to FSSA's right to withdraw them from participation in the program.

Questions?

Recovery Works

INDIANA'S FORENSIC TREATMENT PROGRAM

Kevin Moore
Director, Division of Mental Health & Addiction
Family and Social Services Administration
Kevin.Moore@fssa.in.gov

The numbers

- Nationally 650,000 released annually
- Indiana releases 18,000 from DOC
- CJS is largest referral source to SA tx
- Estimated 6,500 level 5's & 6's to be diverted

Serious Mentally Ill

- 14.5% men, 31% women in jails
- 16% of prisons
- 9% probation, 7% parole

- **General Public is 5.4%**

Addiction

- 80% of State and 45% of Federal prisoners
- 75% of prisoners returning to prison
- 68% of jail inmates
- **General Public is 8.8%**

Treatment That Works

- High Quality & Effective Treatment
  - Evidence Based Practices
  - Medication Assisted Treatment
  - Highly Trained Staff
- Integrated Care
  - Integrated Dual Diagnosis Treatment
  - Partnerships with Primary Care, Court, Probation Officers and Police

Community Supervision and Treatment

- Individualized approach
- Risk and needs assessment to inform plan
- Intensive and targets behavioral change
- Targets multiple criminogenic needs
- Higher risk offenders have increased benefit

Community Supervision and Treatment

- Individualized assessment, treatment planning, and linkage to services
  - Length of Time
  - Types of Programming
  - Funding Resources
- Critical collaboration between Community Supervision and Treatment

Recidivism with Treatment

- Average Recidivism 20% reduction overall
  - 8.2% reduction in felony reconvictions for general offenders
  - 6.3% reduction for returns to prison
  - 4.7% reduction of reconvictions

DMHA Mental Health and Addiction
Forensic Treatment Fund

HEA 1006 - Funds specifically to support services for those without insurance coverage who are involved in the criminal justice system (see eligibility checklist)

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

Forensic Treatment Fund

Two Funding Priorities:

Pre-Incarceration Diversion Services
&
Post-Incarceration Re-Entry Services

Recovery Works
Eligibility Criteria

Eligibility Questions	Yes	No
Is the individual a resident of Indiana?	Eligible	Ineligible
Is the individual at least 18 years old?	Eligible	Ineligible
Is the individual a member of a household with an annual income not exceeding 200% of the federal income poverty level?	Eligible	Ineligible
Has the individual entered the criminal justice system as a felon or with a prior felony conviction?	Eligible	Ineligible

Recovery Works
Reimbursement

- Voucher Reimbursement for the service is not available to an individual if the services being provided are covered under:
  - A policy of accident and sickness insurance
  - A health maintenance organization contract
  - The Medicaid program*
  - The federal Medicare program or any other federal assistance program

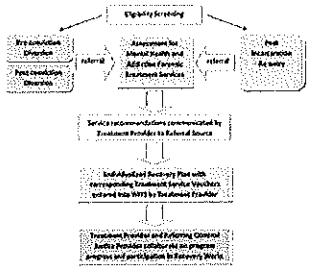
Recovery Works
Designated Treatment Providers

- Certified DMHA Provider
- Designated Recovery Works Treatment Agencies - www.recoveryworks.fssa.in.gov

Recovery Works Services

- Individual, Family and Group Therapy
- Individual, Family and Group Skills Training and Development
- Case Management
- Detoxification
- Medication Evaluation, Training and Support
- Medication Assisted Treatment
- Supportive Employment
- Transitional Housing Assistance
- Community Support Services
- Recovery Supports
- Transportation

Process Flow



Recovery Works

It is...

- A funding source for treatment for those involved with the criminal justice system
- A supplement to community supervision strategies that will decrease recidivism
- Access to individualized treatment and recovery services

It is not...

- A Diversion or Re-entry Program
- A stand-alone solution to community placement for forensic populations
- A punitive measure as discipline for criminal acts

Questions on Recovery Works?

- Recovery.Works@fssa.IN.gov
- www.RecoveryWorks.fssa.IN.gov

Recovery Works

INDIANA'S FORENSIC TREATMENT PROGRAM

Division of Mental Health and Addiction

* GOVERNOR'S *

TASK FORCE

on Drug Enforcement, Treatment & Prevention

LOCAL COORDINATING COUNCILS

Jon Noble, Jim Starkey, and Sharon Burden

LOCAL COORDINATING COUNCIL (LCC)

- Countywide citizen body approved by the Commission, to plan, monitor and evaluate comprehensive local alcohol and drug abuse plans. Serves in the capacity of the substance abuse coalition for their county.
- Identify community drug programs, coordinate community initiatives, design comprehensive, collaborative community strategies and monitor anti-drug activities at the local level.
- LCC's assist the Commission in achieving it's purpose and responsibility by collecting and monitoring local level data and evaluating supported programs.

MEMBERSHIP

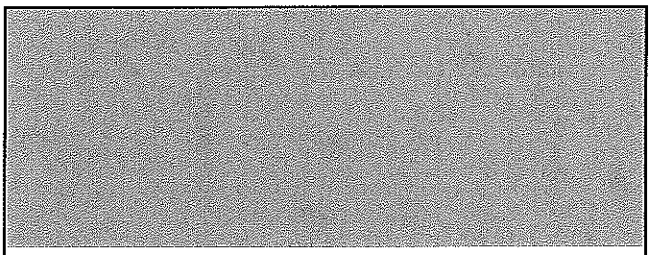
- Who, what, when, how many or for how long is determined at the local level.
- Minimum representation includes:
  - Law enforcement
  - Prevention professionals
  - Treatment
  - Judicial System (judge, prosecutor, probation or community corrections)
  - Education

COMPREHENSIVE COMMUNITY PLAN

- The Plan is:
  - a collaborative effort to assess the impact of substance abuse in the community
  - to collect data
  - to identify issues
  - to evaluate existing and new services

COMPREHENSIVE COMMUNITY PLAN

- Community plan to address AOD issues at the local level. The development of this plan is a process:
- Identification of problems through needs assessments, data collection and community input
- Develop and prioritize clear and concise problem statements.
- Develop measurable and realistic goals
- Develop objectives to address identified problems
- Advocate for change through the release of funds to local agencies and by influencing policies and enforcement
- Evaluate the progress and redirect if needed
- Report findings to state via annual plan updates



LOCAL COORDINATING COUNCIL- ST. JOSEPH COUNTY

The Partnership for Education and Prevention of Substance Abuse | Ms. Sharon Burden

PEPSA

- Focused on the big picture.
- How we respond to a crisis.
- Only community based entity dedicated to substance abuse issues addressing prevention, treatment and criminal justice efforts.

PEPSA

- Youth Prevention and Intervention Initiatives
- Evidenced Based Programs and Practices
- PEPSA Success Highlights

LOCAL COORDINATING COUNCIL- ELKHART COUNTY

Elkhart County Drug Free Partnership | Mr. Jim Starkey and Mr. Jon Noble

DRUG FREE PARTNERSHIP

- Focused on the big picture.
- How we respond to a crisis.
- Only community based entity dedicated to substance abuse issues addressing prevention, treatment and criminal justice efforts.

DRUG FREE PARTNERSHIP

- Youth Prevention and Intervention Initiatives
- Evidenced Based Programs and Practices
- Partnership Success Highlights

* GOVERNOR'S *
TASK FORCE
on Drug Enforcement, Treatment & Prevention

How America's 'heroin city' is turning itself around

By WILSON RING | Oct. 16, 2015 9:14 AM EDT

RUTLAND, Vt. (AP) — Rutland is fed up with heroin.

Take Tom VanEps. He and his neighbors used to just watch, disgusted, as dealers worked Baxter Street, their buyers sometimes littering the ground with used syringes.

Now, he said, they confront the dealers and the junkies.

"We'll make them throw their crap right down that storm drain right there, because that hurts them more than anything," VanEps said recently, sitting on his front steps in the hard-hit Northwest neighborhood. "We've all got kids. We don't want them walking down the street with bare feet and get a needle in their foot."

Authorities credit a variety of police actions, drug treatment programs, social services, new businesses and jobs, and — perhaps most of all — community determination with reducing crime and restoring a sense of hope to this place that has become the poster child for the heroin epidemic sweeping America.

Rutland, population 16,500, is winning national recognition for its efforts. The city's police this month will give a presentation at the Chicago conference of the International Association of Chiefs of Police, chosen after a competitive process, about how a small city confronts addiction.

Crimes including burglaries, vehicle theft and noise complaints are way down, in some cases as much as half, since 2012. A drug treatment center that opened in 2013 is helping more than 400 patients. Since 2011, 92 babies have been born to women in recovery — a promising sign that means 92 fewer babies born addicted to opiates.

No one claims the challenge has been conquered. While many crimes are down, actual drug offenses remain steady.

"One thing this does demonstrate to us, especially when you look at the drug problem, is that those type of crimes, your property crimes, burglaries, larcenies, shoplifting, are usually the type of crimes that are driven by drug addiction," said acting Police Chief David Covell.

In the 19th century, Rutland was a major economic engine of Vermont, where rail lines converged to carry the marble quarried from surrounding communities to the country and the world. It was only three decades ago that competition began closing the quarries; more recently, Rutland lost its title as Vermont's second-largest city.

Many people moved to the country, and what had once been neat single-family homes were divided into apartment houses, many owned by absentee landlords, fertile ground for drug dealers. And when authorities clamped down on the abuse of prescription opioids such as oxycodone, heroin filled the void.

Rutland began building a reputation as "heroin city" in spring 2013, when the police chief at the time, James Baker, held a news conference at which he called the rise of drug addiction "mind-boggling" and said it "rips the social fabric of these neighborhoods apart." The following January, Gov. Peter Shumlin garnered national headlines when he devoted his entire State of the State speech to confronting heroin and other opiates.

Journalists descended on Rutland, eager to tell the story of drug-fueled ugliness in a part of the country long idealized as rustic, idyllic. An illustration of a lumberjack type sitting on a stump and shooting up accompanied a Rolling Stone article titled "The New Face of Heroin."

Though authorities and politicians brought publicity, the problem with drugs — not just heroin — had been snowballing for years, and the city had already begun to confront it.

Locals say Rutland hit bottom in 2012, when 17-year-old Carly Ferro, a star athlete with a bright future, was hit and killed by a car while leaving her job in the Northwest neighborhood. The driver, now in prison, had been huffing chemicals to get high.

"That was a galvanizing event for the city that made a lot of people realize that if we are going to solve these problems, the community needed to participate and take some ownership," said Covell, the police chief. "Just a strict law-enforcement approach isn't going to solve everything."

At the end of 2012, the city created Project Vision, an organization that brings together a variety of groups and individuals — churches, police, social workers, substance abuse experts, businesses and others — so each can do its part in fighting the drug problem.

"When you feel the most hopeless is when you don't have a plan," said Joe Kraus, chairman of Project Vision, which operates with no budget but now includes more than 100 entities united to fight opiates. "We all came together, we put together plans, we're working together, and every day we're making progress."

Now, police often bring social workers along on calls. While police handle the crime, the social workers address the underlying reason for the call, be it drugs, domestic violence or some other ill.

Statewide, Vermont has expanded access to drug treatment, reduced waiting lists for treatment, made available the overdose-reversal drug Narcan, and expanded diversion programs for some people arrested on drug charges.

Chelsea Cole, a 31-year-old Rutlander and former nursing assistant, began drinking heavily at age 18. By 25, she was using pills. By 28, it was heroin. She knew it was time to get help when she found herself hiding under attic insulation from the police after she missed a date in drug court.

She's now been clean for two years and said she couldn't have done it without the support systems Rutland has created.

"I still see some negative comments, but I really think people are starting to understand that this is a crisis, a health crisis, and it needs to be treated as such; it's not just a moral failing," said Cole, a mother of two.

Other forces are at work in Rutland, including economic ones.

Green Mountain Power bought a Rutland-based utility company in 2012 and promised to help revitalize downtown. Now, the occupancy rate is 96 percent, up from about 85 percent three years ago. Last month, the utility proclaimed Rutland the solar capital of New England, generating more sun power per capita than any other city in the region.

A nonprofit group has been working to buy and demolish or redevelop blighted properties in Northwest, the area that generates the most police calls. A lot where a notorious rundown home was just razed, to much relief, is becoming a park.

While the new businesses and revamping of neighborhoods haven't erased the drugs and addiction, they've helped supplant the hopelessness, Rutlanders say. Acknowledgment was just the first step.

"When I was a kid I didn't say, 'I want to be an addict when I grow up,'" Cole said. "I think people are starting to realize that instead of saying 'those junkies,' it's everywhere."